

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01104

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>SAINT MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKVILLE</b>		c. LENGTH OF STAY IN 1b <b>X</b> RURAL MECHANICSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY MARIA BANKINS</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 1 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 4, 1873</b>
9. AGE (in years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALLACE LEE</b>		14. MOTHER'S MAIDEN NAME <b>MARY EDWARDS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. FLORINE FRANKLIN</b>		Address <b>MECHANICSVILLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROSIS</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>10 YEARS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/3/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SAINT JOSEPH</b>		22d. LOCATION (City, town, or county) (State) <b>MORGANZA MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>		24a. REC'D BY REGISTRAR <b>JAN 6 1958</b>	
ADDRESS <b>LEONARDTOWN</b>		24b. REGISTRAR'S SIGNATURE <i>A. H. H. H.</i>	

STATE  
DEPARTMENT

MADE IN U.S.A.

UNITED STATES GOVERNMENT

UNITED STATES DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1105

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Violet</b> Last <b>Bean</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Uriah Goodman Goodwin</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John S. Bean</b>		Address <b>Ridge, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia with convulsions</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Nephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>over 5 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1952</b> , to <b>Jan. 7, 1958</b> , that I last saw the deceased alive on <b>Jan. 7, 1958</b> , and that death occurred at <b>3:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert F. Fuchs</b>		M.D. <b>Leonardtown, Md.</b> DATE SIGNED <b>1/10/58</b>	
PHYSICIAN'S NAME (Type) <b>Robert Fuchs M.D.</b>		<b>Leonardtown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's</b>	22d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JOHN J. BROWN		Male		35		White		1900		Maryland		1935		Baltimore	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. PHYSICIAN		16. BURIAL	
Clerk		Heart Disease		Natural		Hypertension		Chest Pain		Medicine		Dr. Smith		Catholic	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF CLERK		22. SIGNATURE OF CHURCH		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF BURIAL	

**RECEIVED**  
 JAN 18 1938  
 BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01106

1112

Item 7 Film G224 1-27-58 et

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>St. Mary's</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>				d. STREET ADDRESS  			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>Spray</b> Last <b>Beauchamp</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>20</b> Year <b>1958</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Nov. 26, 1895</b>			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <b>62</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			
<b>13. FATHER'S NAME</b> <b>Samuel Beauchamp</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Cecilia Cattin</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>578-24-8933</b>		<b>17. INFORMANT</b> <b>Wilbert F. Beauchamp</b> Address <b>4400 Walker Rd.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO (b) <b>immediate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>W.D. Boyd</i>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>1/21/58</b>			
<b>EXAMINER'S NAME (Type)</b> <b>William D. Boyd M.D.</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>1/23/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>201 Bladensburg Rd, Md.</b>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers</b>				<b>ADDRESS</b> <b>Co. 11th. St. S.E. Washington, D.C.</b>			
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JAN 24 58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Boyd</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JAN 24 1958		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
TIME OF DEATH		PLACE OF BURIAL		CITY		COUNTY		STATE	
10:00 AM		CATHOLIC CHURCH		BALTIMORE		BALTIMORE		MD	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF MINISTER	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

JAN 24 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01107

1113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Film G-225 1/30/58.cac

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>St Mary's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beachville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beachville</i>			
c. LENGTH OF STAY IN 1b <i>Life</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>William</i> Last <i>Carroll</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>22</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 8, 1953</i>		9. AGE (In years last birthday) <i>4</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>William Carroll</i>				14. MOTHER'S MAIDEN NAME <i>May Butler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>William Carroll</i> Address <i>Beachville, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burns Severe (Fire)</i> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased was burned to death when fire broke out in kitchen</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>9:44</i> <i>1 22 19 58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Beachville St Mary's Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W D Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>WILLIAM D BOYD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>1/22/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/24/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Peter's Church</i>		22d. LOCATION (City, town, or county) (State) <i>Bridge Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McClure Mattingly</i> ADDRESS <i>Leonardtown, Md.</i>				24a. REC'D BY REGISTRAR <i>W D Boyd</i>		24b. REGISTRAR'S SIGNATURE <i>W D Boyd</i>	
				DATE <i>JAN 24 1958</i>			

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

BUREAU V. 3

JAN 24 1958

RECEIVED



## 11114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Steven Clayton</u>				4. DATE OF DEATH Month Day Year <u>Jan. 29, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/1957</u>		9. AGE (in years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. <u>1 23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Ralph Clayton</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rosalee Lawrence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>George R Clayton - Piney Point, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. D. Boyd M. D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. D. Boyd M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-31-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Francis Xavier</u>		22d. LOCATION (City, town, or county) (State) <u>St George Island, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clark Hattingsley Leonardtown, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2078295XV5

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text on the right side.

BUREAU V. 4

JAN 31 1958

RECEIVED

1115

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Marys</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dr. Office</b>				/d. STREET ADDRESS <b>Rural</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Floyd</b> Last <b>Downes, Jr.</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 4. 1957</b>		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James F. Downes, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Hazel Nations</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>James F. Downes, Sr. - Mechanicsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Leonardtown</b>	(County) <b>St. Marys</b>
21. I certify that I attended the deceased from <b>Jan 9<sup>th</sup></b> , 19 <b>58</b> , to <b>Jan 10<sup>th</sup></b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 10<sup>th</sup></b> , 19 <b>58</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles Greenwell</b>				ADDRESS (Street, city or town, state) <b>Leonardtown Md.</b>		DATE SIGNED <b>Jan 10 1958</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL</b>				<b>Leonardtown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Morganza, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

2078304XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NEW YORK

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
JAN 4 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		GUNSHOT WOUNDS		DR. JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968	

BUREAU V. 2

JAN 12 1968

RECEIVED

TO HOSPITAL OR OUTDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

011110

1116

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Joseph</b> Last <b>Eberle</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Warren Francis Eberle</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		17. INFORMANT <b>Warren F. Eberle</b> Address <b>Valley Lee, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute overwhelming infection</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>probably pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 27, 1957</b> to <b>Jan 28, 1958</b> , that I last saw the deceased alive on <b>Jan 31, 1958</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Mechanicsville, Md</b> DATE SIGNED	
ACTUAL SIGNATURE <b>J. Roy Guyther</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M.D.</b> <b>Mechanicsville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 31 1958</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>			

2078183XV4



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01111

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oraville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oraville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stephen Leon Graves</u>		4. DATE OF DEATH Month Day Year <u>Jan. 11 19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Graves</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hayden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Mary L. Graves - Oraville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Pyonephrosis - prostatic hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertrophy</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1948</u> , 19 <u>58</u> , to <u>Jan 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>58</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Roy Guyther</u>		DATE SIGNED <u>Mechanicsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Roy Guyther, MD</u>		<u>Mechanicsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COUNTY OF STATE DEPARTMENT OF HEALTH		NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH	
OCCUPATION MARITAL STATUS COLOR		CAUSE OF DEATH PLACE OF DEATH DATE OF DEATH	
SIGNATURE OF PHYSICIAN SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES SIGNATURE OF CORONER	
SIGNATURE OF JUDGE SIGNATURE OF CLERK		SIGNATURE OF DEPUTY CLERK SIGNATURE OF ASSISTANT CLERK	

BUREAU V. 81

JAN 15 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oaksville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural X Oaksville</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Gray</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> , Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>5</b>	11. IF UNDER 24 HRS. Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Gray</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Mable Suter</b>		Address <b>Mechanicsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.1</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Galilee</b>	22d. LOCATION (City, town, or county) (State) <b>Oaksville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. D. Boyd</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1958		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. J. JONES		M.D.	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
JAN 15 1913		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS		SIGNATURE OF ASSISTANT		TITLE	
JAN 16 1958		BALTIMORE, MD.		AUTOPSY		NO		J. J. JONES		M.D.	
DATE OF BURIAL		PLACE OF BURIAL		FINDINGS		REMARKS		SIGNATURE OF ASSISTANT		TITLE	
JAN 17 1958		BALTIMORE, MD.		AUTOPSY		NO		J. J. JONES		M.D.	

RECEIVED  
JAN 20 1958  
BUREAU V. 1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011113

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>2 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>902-B, MOQ</b>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Homer</b> Last <b>HART</b>				4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1919</b>		9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Aviator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>S. M. HART</b>				14. MOTHER'S MAIDEN NAME <b>Esther Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>3/41 to 1/58 467 18 4288</b>		17. INFORMANT <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of Brain</b> DUE TO <b>860X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Skull Fracture</b> DUE TO (c) <b>Trauma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laceration of spinal cord</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>8:21 p.m. Jan 14 19 58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>USNAS, (County) St. Mary's, Md. (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>PAUL LEVINE, LT MC USNR, USNAS, Patuxent River, Md.</b>				DATE SIGNED <b>14 January 1958</b>			
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 1958</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BUENA

TABLE 1. *Continued*

\_\_\_\_\_

1120

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XHollywood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James King Heard</b>				4. DATE OF DEATH Month Day Year <b>January 14, 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1887</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dent Heard</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-1887</b>		17. INFORMANT <b>Rosie C. Heard</b> Address <b>Hollywood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1954, to <b>Jan. 14</b> , 1958, that I last saw the deceased alive on <b>Jan. 13</b> , 1958, and that death occurred at <b>9 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William D. Boyd M.D.</b> <b>1/14/58</b> Leonardtwn, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		MARRIAGE Married		OCCUPATION Retired	
DATE OF DEATH Jan 20 1938		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		COUNTRY United States	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS Several days		PREVIOUS ILLNESS None		PREVIOUS SURGERY None		PREVIOUS TRAUMA None	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
DATE OF SIGNATURE Jan 20 1938		DATE OF SIGNATURE Jan 20 1938		DATE OF SIGNATURE Jan 20 1938		DATE OF SIGNATURE Jan 20 1938		DATE OF SIGNATURE Jan 20 1938		DATE OF SIGNATURE Jan 20 1938	

BUREAU V. E.

JAN 20 1938

RECEIVED

1121

CERTIFICATE OF DEATH

011115

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X St. Georges Island</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hosp.</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eugene ----- Henderson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 17 19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1883</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Henderson</b>				14. MOTHER'S MAIDEN NAME <b>Lula Twillie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Queenie J. Henderson -</b>		Address <b>St. Georges Island, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) <b>-----</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombophlebitis of Rt Leg.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 19 57</b> to <b>17 Jan 19 58</b> that I last saw the deceased alive on <b>17 Jan 19 58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>RLB 024414</b> DATE SIGNED <b>19 Jan 58</b>							
ACTUAL SIGNATURE <b>Ernest D. Rehm</b> M.D.				PHYSICIAN'S NAME (Type) <b>Ernest D. Rehm</b> <b>Lexington Park, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Georges Methodise</b>		22d. LOCATION (City, town, or county) (State) <b>St. Georges Island, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quesada</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1958 JAN 21

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01116

Reg. Dist. No.

1122

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Mary's</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>St. Mary's</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Great Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>USNAS, Patuxent River</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NAS Annex, Qtrs I-9</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <u>Timothy</u></span> <span>Middle <u>Joseph</u></span> <span>Last <u>KEANE, Jr.</u></span> </div>							
<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>6</u> Year <u>19 58</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Oct. 15, 1925</u>		<b>9. AGE</b> (In years last birthday) <u>32</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>			
<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Aviator</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>USMC</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Timothy Joseph KEANE, Sr.</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Not available</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>62-24-2049</u>		<b>17. INFORMANT</b> <u>USNAS, Patuxent River, Md.</u> <u>Official Navy Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>860X</u> DUE TO (b) <u>Basilar Skull Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Jet aircraft explosion, in air.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11 58 a.m. Jan 6 1958</u>		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>In air</u>			
<b>20f. (City or town)</b> <u>Great Mills, St. Mary's, Md.</u>		<b>20g. (County)</b> <u>Rural</u>		<b>20h. (State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>P. LEVINE, LT MC USNR, USNAS, Patuxent River, Md.</u>				<b>DATE SIGNED</b> <u>6 Jan 1958</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Wm. D. Boyd MD</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1-10-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Virginia</u>		<b>22e. (State)</b> <u>Virginia</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers, 1400 Chapin St. Washington, D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 13 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate filing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 13 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01117

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River, Md.</b> c. LENGTH OF STAY IN lb <b>2 yr 2mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Ohio</b> <span style="float: right;">b. COUNTY <b>Belmont</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martin's Ferry</b> d. STREET ADDRESS <b>Box 334</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Zane</b> Middle <b>Henry</b> Last <b>KRENKE</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>14</b> Year <b>19 58</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec 15, 1926</b>		<b>9. AGE</b> (In years last birthday) <b>31</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>14</b> Days <b>19</b>		<b>IF UNDER 24 HRS.</b> Hours <b>58</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Navy</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Virginia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George August Krenke</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Rose (?)</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> [Yes, no, or unknown] <b>Yes</b> <b>10/44 to 1/58</b>				<b>16. SOCIAL SECURITY NO.</b> <b>276 22 5832</b>				<b>17. INFORMANT</b> <b>Official Navy Records</b> <b>USNAS, Patuxent River, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Laceration of Brain</b> DUE TO <b>860x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Skull Fracture</b> DUE TO (c) <b>Trauma</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion.</b>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>8:21</b> a. m. <b>14 Jan 19 58</b>				<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> of work <b>Not while</b> <input type="checkbox"/> of work				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>				<b>20f. (City or town)</b> <b>USNAS</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>Paul Levine</b> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.</b>													
<b>ACTUAL SIGNATURE</b> <b>Wm. D. Boyd M.D.</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>14 January 1958</b>					
<b>EXAMINER'S NAME</b> (Type) <b>Wm. D. BOYD, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>Jan. 20, 1958</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>RIVERVIEW</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>MARTIN'S FERRY, OHIO</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. CLARKE MATTINGLEY</b>						<b>ADDRESS</b> <b>LEONARDTOWN, MD.</b>							
<b>24a. REC'D BY REGISTRAR</b> <b>JAN 20 '58</b>						<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. Leach</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

RECEIVED  
BUREAU V. S.

1 JAN 28 1958

BUREAU V. S.

RECEIVED

<p>NAME: [illegible]</p>		<p>DATE: [illegible]</p>	
<p>AGE: [illegible]</p>		<p>SEX: [illegible]</p>	
<p>HEIGHT: [illegible]</p>		<p>WEIGHT: [illegible]</p>	
<p>HAIR: [illegible]</p>		<p>COLORED: [illegible]</p>	
<p>SCARS: [illegible]</p>		<p>OTHER: [illegible]</p>	
<p>EDUCATION: [illegible]</p>		<p>OCCUPATION: [illegible]</p>	
<p>RESIDENCE: [illegible]</p>		<p>DATE OF BIRTH: [illegible]</p>	
<p>PLACE OF BIRTH: [illegible]</p>		<p>DATE OF DEATH: [illegible]</p>	
<p>CAUSE OF DEATH: [illegible]</p>		<p>MANNER OF DEATH: [illegible]</p>	
<p>TOXICOLOGY: [illegible]</p>		<p>LABORATORY: [illegible]</p>	
<p>PATHOLOGY: [illegible]</p>		<p>FORENSIC: [illegible]</p>	
<p>ANTHROPOLOGY: [illegible]</p>		<p>PHYSIOLOGY: [illegible]</p>	
<p>PSYCHOLOGY: [illegible]</p>		<p>PHYSICS: [illegible]</p>	
<p>CHEMISTRY: [illegible]</p>		<p>BIOLOGY: [illegible]</p>	
<p>GEOLGY: [illegible]</p>		<p>ASTRONOMY: [illegible]</p>	
<p>METEOROLOGY: [illegible]</p>		<p>CLIMATE: [illegible]</p>	
<p>SOIL: [illegible]</p>		<p>WATER: [illegible]</p>	
<p>AIR: [illegible]</p>		<p>LAND: [illegible]</p>	
<p>SEA: [illegible]</p>		<p>SKY: [illegible]</p>	
<p>SPACE: [illegible]</p>		<p>TIME: [illegible]</p>	
<p>TEMPERATURE: [illegible]</p>		<p>PRESSURE: [illegible]</p>	
<p>WIND: [illegible]</p>		<p>MOON: [illegible]</p>	
<p>SUN: [illegible]</p>		<p>STARS: [illegible]</p>	
<p>PLANETS: [illegible]</p>		<p>GALAXIES: [illegible]</p>	
<p>UNIVERSE: [illegible]</p>		<p>TIME: [illegible]</p>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b> c. LENGTH OF STAY IN 1b <b>2 5/12 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b> d. STREET ADDRESS <b>913-A, MOQ</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Wylly LAMAR, Jr.</b>		4. DATE OF DEATH Month Day Year <b>January 14 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1919</b>
9. AGE (in years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Aviator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W. W. LAMAR</b>		14. MOTHER'S MAIDEN NAME <b>Mary Clarke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 6/41 to 1-58</b>		16. SOCIAL SECURITY NO. <b>224 52 6140</b>	
17. INFORMANT <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of Brain</b> 860X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Skull Fracture</b> DUE TO (c) <b>Trauma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b> <b>Immediately</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laceration of spinal cord</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (Instrument) landing explosion.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>8:21 Jan 14, 1958</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>	
20f. (City or town) <b>Patuxent River, St. Mary's, Md.</b>		20g. (State) <b>USNAS County</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.			
ACTUAL SIGNATURE <b>WM. D. BOYD, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 17, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY LEONARDTOWN, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. D. Boyd</b>		DATE SIGNED <b>14 January 1958</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		Jan 15, 1903	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York		Boston		Died of		Suicide	
Occupation		Education		Previous Illness		Injury	
Teacher		High School		None		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. Smith		W. Jones		A. Brown		C. White	

RECEIVED

RECEIVED  
 JAN 20 1903  
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01119
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>St Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLTON POINT</b>			c. LENGTH OF STAY IN 1b <b>26 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colton Point</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM ADELBERT LEE</b>					4. DATE OF DEATH Month Day Year <b>JANUARY 17 19 58</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3, 1878</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LAWYER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ADELBERT H. LEE</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>ADELBERT W. LEE.</b>		Address <b>3211 PENNSYLVANIA AV. WASHINGTON D.C.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OLD + RECENT MYOCARDIAL INFARCTION</b> DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BURNS OF BUTTOCKS + THIGHS</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned when he backed into stove</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>1/7/58 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Colton Point St. Marys Md.</b>		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Paul F. Guerin</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>			22d. LOCATION (City, lawn, or county) <b>SUITLAND MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Guerin</b>					ADDRESS <b>Home - Wash D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Paul F. Guerin</b>	

BUREAU V. S.

JAN 22 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01120

1126

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Mary's</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>USNAS, Patuxent River</u> c. LENGTH OF STAY IN 1b <u>10 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> d. STREET ADDRESS <u>154 W. Rennel</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edward</u> Middle <u>Reynold</u> Last <u>LIBERDA</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>14</u> Year <u>19 58</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec 29, 1926</u>		<b>9. AGE</b> (In years last birthday) <u>31</u> yrs.		<b>10. FUND YEAR</b> Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Naval Airman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Navy</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Dakota</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Theodore H. Liberda</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise (?)</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>2/44 to 1/58</u>				<b>16. SOCIAL SECURITY NO.</b> <u>502 16 2859</u>		<b>17. INFORMANT</b> <u>Official Navy Records</u> <u>USNAS, Patuxent River, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive, Severe Burns</u> <u>860x</u> DUE TO (b) <u>Fire</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>Immediately</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Aircraft (instrument) landing explosion</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>8:21</u> o. m. <u>Jan 14, 19 58</u>				<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>		<b>20f. (City or town)</b> <u>Patuxent River, St. Mary's, Md.</u> (State) <u>USNAS (County)</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <u>Paul Levine</u> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MARYLAND</b>											
ACTUAL SIGNATURE <u>Wm. D. Boyd</u> <b>EXAMINER'S NAME (Type)</b> <u>WM. D. BOYD, M.D.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>14 January 1958</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>1-22-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>James town North Dakota</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>North Dakota</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCluskey Mattingly Leonard town, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 20 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Cliff Leach</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



243 07

USUAL TOLERANCE

1514

43

201, 8, 12

518

7/20/04, 15:33

SECRET

esl

17. 15:8

• • • • •

**BUREAU V. B.**

4N 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1127

## CERTIFICATE OF DEATH

Reg. Dist. No.

01121

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>XXXX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HURRY</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>KELVIN</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 23, 1957</b>
9. AGE (In years last birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>28</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWRENCE SOMMERVILLE</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE MILLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>LOUISE MILLS</b>		Address <b>HURRY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/20</b> , 19 <b>58</b> , to <b>1/20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10 AM</b> , 19 <b>58</b> , and that death occurred at <b>10:05</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D. <b>Leonardtown Maryland</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>DR. CHARLES GREENWELL MD.</b>		<b>LEONARDTOWN, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-20-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>	22d. LOCATION (City, town, or county) (State) <b>LEONARDTOWN MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>		24a. REC'D BY REGISTRAR <b>LEONARDTOWN, MD.</b> 24b. REGISTRAR'S SIGNATURE <b>DATE JAN 21 '58</b>	

2078212XV5

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

JAN 21 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03746

1. PLACE OF DEATH a. COUNTY <u>Potomac River</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Richmond</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Off Raged Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warsaw</u> <u>83X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse</u> <u>Wallace</u> <u>Mohler, Jr.</u>		4. DATE OF DEATH Jan, Month Day Year <u>Feb.</u> <u>3</u> <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1928</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Lexington, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Jesse W. Mohler, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Emma Barger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. Mary D. Mohler-</u>		Address <u>Warsaw, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>929.8</u> IMMEDIATE CAUSE: (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u> INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>returning from duck blind, boat over turned,</u>	
20c. TIME OF INJURY Month, Day, Year <u>9</u> Hour <u>a. m.</u> <u>1/3/</u> <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>potomac river</u>	20f. (City or town) (County) (State) <u>off Raged Point, Va.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Wm. D. Boyd</u>		DATE SIGNED <u>3/29/58</u>	
EXAMINER'S NAME (Type) <u>Wm. D. Boyd, MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Jackson Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Lexington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>		24a. REC'D BY REGISTRAR <u>APR 2 '58</u>	
ADDRESS <u>- Leonardtown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>-----</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURLAU V. S.

APR 2 1958

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal of remains.

VS. A15ME(S)  
5M 9/55

# 1129 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01122

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Bergen</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>4 mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Little Ferry</b> 67X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>31 Columbus Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>George</b> Last <b>MORGAN, Jr.</b>			4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 9, 1933</b>	9. AGE (In years last birthday) <b>24</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Harry George Morgan, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Helen Irene (?)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>151 26 0305</b>		17. INFORMANT <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Severe Burns</b> 860X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fire</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion.</b>			
20c. TIME OF INJURY Hour <b>8:21</b> o. m. <b>xx</b> Month, Day, Year <b>Jan 14, 1958</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>USNAS</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . <b>Paul Levine</b> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.</b>					
ACTUAL SIGNATURE <b>Wm. D. Boyd M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN, 20, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LITTLE FERRY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MD</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. D. Boyd</b>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John J. Jones		45		Male		Caucasian		Jan 2, 1958		Home	
Occupation		Cause of Death		Manner of Death		Disease or Injury		Organ or System Affected		Time of Death	
Teacher		Heart Disease		Natural		Coronary Artery Disease		Heart		10:30 AM	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

**RECEIVED**  
 JAN 20 1958  
 BUREAU V. 1

1130

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clements</b>				c. LENGTH OF STAY IN 1b <b>6 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clements</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Webster</b> Last <b>Owens</b>				4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1, 1866</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Clements, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wilfred Owens</b>				14. MOTHER'S MAIDEN NAME <b>Mary Owens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. Ernest Quade Clements, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Bleeding</b> 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown cause</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Nov</b> , 19 <b>57</b> , to <b>12 Jan</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11 Jan</b> , 19 <b>58</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David L. Mossman</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>David L. Mossman M.D.</b>				<b>Mechanicsville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
1. NAME OF DECEASED		2. SEX	
3. COLOR		4. OCCUPATION	
5. MARITAL STATUS		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. MEDICAL HISTORY		10. HISTORY OF PRESENT ILLNESS	
11. HISTORY OF PREVIOUS ILLNESSES		12. HISTORY OF SURGERY	
13. HISTORY OF DRUGS		14. HISTORY OF ALCOHOL	
15. HISTORY OF TOBACCO		16. HISTORY OF OTHER HABITS	
17. HISTORY OF TRAUMA		18. HISTORY OF INFECTION	
19. HISTORY OF ALLERGIC REACTIONS		20. HISTORY OF CHRONIC DISEASES	
21. HISTORY OF ACUTE DISEASES		22. HISTORY OF CONGENITAL DEFECTS	
23. HISTORY OF ACQUIRED DEFECTS		24. HISTORY OF OTHER DEFECTS	
25. HISTORY OF OTHER DEFECTS		26. HISTORY OF OTHER DEFECTS	
27. HISTORY OF OTHER DEFECTS		28. HISTORY OF OTHER DEFECTS	
29. HISTORY OF OTHER DEFECTS		30. HISTORY OF OTHER DEFECTS	
31. HISTORY OF OTHER DEFECTS		32. HISTORY OF OTHER DEFECTS	
33. HISTORY OF OTHER DEFECTS		34. HISTORY OF OTHER DEFECTS	
35. HISTORY OF OTHER DEFECTS		36. HISTORY OF OTHER DEFECTS	
37. HISTORY OF OTHER DEFECTS		38. HISTORY OF OTHER DEFECTS	
39. HISTORY OF OTHER DEFECTS		40. HISTORY OF OTHER DEFECTS	
41. HISTORY OF OTHER DEFECTS		42. HISTORY OF OTHER DEFECTS	
43. HISTORY OF OTHER DEFECTS		44. HISTORY OF OTHER DEFECTS	
45. HISTORY OF OTHER DEFECTS		46. HISTORY OF OTHER DEFECTS	
47. HISTORY OF OTHER DEFECTS		48. HISTORY OF OTHER DEFECTS	
49. HISTORY OF OTHER DEFECTS		50. HISTORY OF OTHER DEFECTS	
51. HISTORY OF OTHER DEFECTS		52. HISTORY OF OTHER DEFECTS	
53. HISTORY OF OTHER DEFECTS		54. HISTORY OF OTHER DEFECTS	
55. HISTORY OF OTHER DEFECTS		56. HISTORY OF OTHER DEFECTS	
57. HISTORY OF OTHER DEFECTS		58. HISTORY OF OTHER DEFECTS	
59. HISTORY OF OTHER DEFECTS		60. HISTORY OF OTHER DEFECTS	
61. HISTORY OF OTHER DEFECTS		62. HISTORY OF OTHER DEFECTS	
63. HISTORY OF OTHER DEFECTS		64. HISTORY OF OTHER DEFECTS	
65. HISTORY OF OTHER DEFECTS		66. HISTORY OF OTHER DEFECTS	
67. HISTORY OF OTHER DEFECTS		68. HISTORY OF OTHER DEFECTS	
69. HISTORY OF OTHER DEFECTS		70. HISTORY OF OTHER DEFECTS	
71. HISTORY OF OTHER DEFECTS		72. HISTORY OF OTHER DEFECTS	
73. HISTORY OF OTHER DEFECTS		74. HISTORY OF OTHER DEFECTS	
75. HISTORY OF OTHER DEFECTS		76. HISTORY OF OTHER DEFECTS	
77. HISTORY OF OTHER DEFECTS		78. HISTORY OF OTHER DEFECTS	
79. HISTORY OF OTHER DEFECTS		80. HISTORY OF OTHER DEFECTS	
81. HISTORY OF OTHER DEFECTS		82. HISTORY OF OTHER DEFECTS	
83. HISTORY OF OTHER DEFECTS		84. HISTORY OF OTHER DEFECTS	
85. HISTORY OF OTHER DEFECTS		86. HISTORY OF OTHER DEFECTS	
87. HISTORY OF OTHER DEFECTS		88. HISTORY OF OTHER DEFECTS	
89. HISTORY OF OTHER DEFECTS		90. HISTORY OF OTHER DEFECTS	
91. HISTORY OF OTHER DEFECTS		92. HISTORY OF OTHER DEFECTS	
93. HISTORY OF OTHER DEFECTS		94. HISTORY OF OTHER DEFECTS	
95. HISTORY OF OTHER DEFECTS		96. HISTORY OF OTHER DEFECTS	
97. HISTORY OF OTHER DEFECTS		98. HISTORY OF OTHER DEFECTS	
99. HISTORY OF OTHER DEFECTS		100. HISTORY OF OTHER DEFECTS	

RECEIVED  
JAN 15 1958  
BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01124

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b> c. LENGTH OF STAY IN 1b <b>2yr 1mo</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Massachusetts</b> <span style="float: right;">b. COUNTY <b>Essex</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Lawrence</b> d. STREET ADDRESS <b>50 Congress St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Vita</b> Middle <b>Adam</b> Last <b>PAULASKAS</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>14</b> Year <b>19 58</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Aug 4, 1927</b>		<b>9. AGE</b> (In years last birthday) <b>30</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Navy</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Massachusetts</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Adam Paulauskas</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret (?)</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> [Yes, no, or unknown] <b>Yes</b> <b>10/45 to 1/58</b>				<b>16. SOCIAL SECURITY NO.</b> <b>033 14 2644</b>		<b>17. INFORMANT</b> <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns, Severe</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>8:21 a.m. Jan 14, 1959</b>				<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Woods</b> <b>20f. (City or town)</b> <b>USNAS</b> (State) <b>Patuxent River, St. Mary's, Md.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>Paul Levine</b> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MARYLAND</b> ACTUAL SIGNATURE _____ M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Wm. D. Boyd</b> <b>WM. D. BOYD, M.D.</b> EXAMINER'S NAME (Type) _____ ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>JAN. 20, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>LEONARDTOWN</b>		<b>22d. LOCATION</b> (City, town, or county) <b>BROCKTON,</b> (State) <b>MASS.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. CLARKE MATTINGLEY</b>				<b>24a. REC'D BY REGISTRAR</b> <b>JAN 20 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Alfred...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01125

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> <span style="float: right;">b. COUNTY <b>Cooper</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>6 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Booneville</b> <span style="float: right;">62x-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>403 3rd Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Larry</b> Middle <b>Wayne</b> Last <b>RUDDER</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>14,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1937</b>		9. AGE (In years last birthday) <b>20</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Marvine Brummal Rudder</b>			
14. MOTHER'S MAIDEN NAME <b>Leona Frederica (?)</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes 6/55 to 1/58</b>			
16. SOCIAL SECURITY NO. <b>495 36 7099</b>				17. INFORMANT <b>Official Navy Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of Brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Skull Fracture</b> (c), stating the underlying cause lost. <b>Trauma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laceration of spinal cord</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:21 a.m. Jan 14, 19 58</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>			
20f. (City or town) <b>USNAS</b>		20g. (County) <b>St. Mary's, Md.</b>		20h. (State) <b>MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>Paul Levine</b> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.</b>							
ACTUAL SIGNATURE <b>Wm. D. Boyd, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>14 January 1958</b>			
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 20, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONEVILLE</b>			
22d. LOCATION (City, town, or county) <b>BOONEVILLE</b>		22e. (State) <b>MISSOURI</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>			
ADDRESS <b>LEONARDTOWN, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1133

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01126

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>1 yr 8mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>41 Anderson Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>Olan</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>January</b> Day <b>14,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 31, 1921</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Velma Black</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>5/40 to 1/58 414 14 5006</b>		17. INFORMANT <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture, Parietal and Frontal Skull,</b> <b>860X</b> DUE TO <b>Depressed</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>8:21</b> o. m. <b>Jan 14 19 58</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>USNAS</b> (County) <b>St. Mary's</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Paul Levine</b> <b>PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.</b>				DATE SIGNED <b>14 January 1958</b>			
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tell City</b>		22d. LOCATION (City, town, or county) (State) <b>Tell City, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

**BUREAU V.**

8561 02 N.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01127

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Genesee</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>9 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flint</b> 59x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>8049 Barden</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>MC</b> Last <b>THURAU</b>				4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 13, 1927</b>		9. AGE (In years last birthday) <b>31</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Airman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Stanley Tharau</b>				14. MOTHER'S MAIDEN NAME <b>Trene Christine (?)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>12/47 to 1/58 368 24 6298</b>		17. INFORMANT <b>Official Navy Records</b> <b>USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Skull Fracture</b> 860X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft (instrument) landing explosion.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>8:21</b> Jan <b>14</b> , 19 <b>58</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>USNAS</b> (County) _____ (State) _____ <b>Patuxent River, St. Mary's, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>PAUL LEVINE, LT MC USNR, USNAS, Patuxent River, Md.</b>		DATE SIGNED <b>14 January 1958</b>					
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FLINT</b>		22d. LOCATION (City, town, or county) (State) <b>MICHIGAN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

BUREAU V. B.

11 JAN 20 1958

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drayden</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drayden</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Aloysius</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1957</b>
9. AGE (In years lost birthday) yrs. <b>4</b> Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Warren Aloysius Young</b>	
14. MOTHER'S MAIDEN NAME <b>Bessie Ann Whalen</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bessie Ann Whalen Drayden, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho - Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-14-58</b> to <b>1-14-58</b> , that I last saw the deceased alive on <b>1-14-58</b> , 19 <b>19</b> , and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park Md.</b> DATE SIGNED <b>1-14-58</b>	
PHYSICIAN'S NAME (Type) <b>W.H. PATRICK</b>		Lexington Park, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's</b>	22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Patrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2078171XV4



1136

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kenneth E. Young</b>				4. DATE OF DEATH Month Day Year <b>Jan. 1, 1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 57</b>		9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard D. Young</b>				14. MOTHER'S MAIDEN NAME <b>Iva Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>-----</b>		17. INFORMANT <b>Leonard D. Young - Lexington Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Virus</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 Dec</b> , 19 <b>57</b> , to <b>1 Jan</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest D. Rehm</b>				ADDRESS (Street, city or town, state) <b>R1, Box 4414, Lexington Park, Md.</b> DATE SIGNED <b>2 Jan 58</b>			
PHYSICIAN'S NAME (Type) <b>Ernest D. Rehm, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 1 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

2078403XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1138

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1891		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DECEASED'S ADDRESS 1234 N. Tenth St., Baltimore, Md.		12. DECEASED'S PHONE 1234		13. DECEASED'S SOCIAL SECURITY NO. 1234 56789		14. DECEASED'S MARRIAGE LICENSE NO. 1234		15. DECEASED'S VOTER REGISTRATION NO. 1234	
16. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		17. DECEASED'S LAST KNOWN PHONE 1234		18. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		19. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		20. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
21. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		22. DECEASED'S LAST KNOWN PHONE 1234		23. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		24. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		25. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
26. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		27. DECEASED'S LAST KNOWN PHONE 1234		28. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		29. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		30. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
31. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		32. DECEASED'S LAST KNOWN PHONE 1234		33. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		34. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		35. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
36. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		37. DECEASED'S LAST KNOWN PHONE 1234		38. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		39. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		40. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
41. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		42. DECEASED'S LAST KNOWN PHONE 1234		43. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		44. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		45. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
46. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		47. DECEASED'S LAST KNOWN PHONE 1234		48. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		49. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		50. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
51. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		52. DECEASED'S LAST KNOWN PHONE 1234		53. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		54. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		55. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
56. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		57. DECEASED'S LAST KNOWN PHONE 1234		58. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		59. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		60. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
61. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		62. DECEASED'S LAST KNOWN PHONE 1234		63. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		64. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		65. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
66. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		67. DECEASED'S LAST KNOWN PHONE 1234		68. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		69. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		70. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
71. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		72. DECEASED'S LAST KNOWN PHONE 1234		73. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		74. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		75. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
76. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		77. DECEASED'S LAST KNOWN PHONE 1234		78. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		79. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		80. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
81. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		82. DECEASED'S LAST KNOWN PHONE 1234		83. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		84. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		85. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
86. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		87. DECEASED'S LAST KNOWN PHONE 1234		88. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		89. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		90. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
91. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		92. DECEASED'S LAST KNOWN PHONE 1234		93. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		94. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		95. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	
96. DECEASED'S LAST KNOWN ADDRESS 1234 N. Tenth St., Baltimore, Md.		97. DECEASED'S LAST KNOWN PHONE 1234		98. DECEASED'S LAST KNOWN SOCIAL SECURITY NO. 1234 56789		99. DECEASED'S LAST KNOWN MARRIAGE LICENSE NO. 1234		100. DECEASED'S LAST KNOWN VOTER REGISTRATION NO. 1234	

BUREAU V. E.

JAN 15 1958

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.